



**MOUNTAIN STATES
HEALTH ALLIANCE**

MSHA Assessment Report

Pt Name: [REDACTED]
 Pt ID: [REDACTED]
 DOB: [REDACTED]
 Adm DTime: 10/17/2012 01:34:00PM
 Dsch DTime: 10/31/2012 4:00:00PM
 Dx: MALAISE & FATIGUE NEC
 Allergies: No Known Allergies, No Known Drug Allergies, No Known Food Allergies

MRN: [REDACTED]
 Acct No: [REDACTED]
 Age/Sex: 37Y/F
 Attn Dr: [REDACTED]
 Entity: JCMC

ED Nursing Assessment

Assessment Sts 4 Complete Collected DTime 10/17/2012 11:45
 Last Revised By [REDACTED]

ED Nursing Assessment

Functional Assessment no problems identified	Yes	Barriers to Communication no problems identified	Yes
Barriers to Care/Learning no problems identified	Yes	Tetanus Status	Undetermined
No Nutrition Problems Identified	Yes	Potential Abuse / Neglect Identified	No
Tobacco Use?	Never Smoker (CDC_4)	Alcohol Use	No
Substance Abuse	No	Lives with	Family

ED Pain Hx

Pain Location denies

ED Neurological

Orientation	Person, Place, Time, Situation	GCS Eye Opening (ED)	(3) To Voice
GCS Verbal Response (ED)	(5) Oriented	GCS Motor Response (ED)	(6) Obeys Command
Glasgow Coma Scale Score ED	14	Level of Consciousness	Verbal
Consciousness Other	Cooperative	Neurological Weakness	Moves all extremities equally

ED Genitourinary

Elimination	Foley	Catheter Size	16
Catheter	Yes	Catheter Insertion	New insertion
Catheter Insert Date	2012-10-17	Catheter Insert Time	11:35
Color of urine	Amber	Urine Characteristics	Clear

Pt. Name: [REDACTED]

WEAKNESS

Johnson City Medical Center

Emergency Department QualChart © Page 1 of 2

Initial Encounter Time	Mode of Arrival	Instructions: Circle pertinent positive findings. Backslash pertinent negative findings. INDICATORS: * HQI ▲ PQRI
Encounter Date: 10/17/12	Vital Signs: Stable except: BP 120/80 Pulse 89 R Rate 24 Temp 98.6	
	Other: Cardiac Monitor: Rate: NSR Brady Tachy Rhythm: Sinus Afib Junctional Ectopy: None PVCs PACs	
	HX from Patient Unobtainable due to: Dementia Altered Mental Status Extremis Other:	
	HX from: Patient Family Caretaker EMS Interpreter Medical Records LMP:	

CHIEF COMPLAINT: This is a 37 year old male / female who presents with a complaint of: Weakness Dizziness Loss of Balance (Circle if Appropriate)

ONSET/DURATION Started 2 Min Hours Days Weeks Ago Still Present Resolved Worse Since:

TIMING Constant Intermittent Episodes Lasting Sec Min Hours Days Weeks

SEVERITY Initially: Mild Moderate Severe Currently: None Mild Moderate Severe

CHARACTER Head Spinning Room Spinning Lightheaded Weak Dizzy Unable to Describe

AGGRAVATING Exertion Headache Position Change / Supine to Erect Change in Head Position Nothing

ALLEVIATING Rest Lying Down Closing Eyes Glucose Turning Head Vagal Maneuvers Nothing

ASSOCIATED SIGNS AND SYMPTOMS Negative Nausea / Vomiting Diaphoresis Tinnitus Chest Pain SOB Palpitations Unsteady Gait

GI Blood Loss Visual Changes Oral Intake

Change in Medication Change in Diet OTC Meds

RELATED HX Similar Episode / Dx as: 14

Cardiac Risk Factors: Negative Diabetes Hypertension Smoking Elevated Lipids Family History Prior MI / CAD -CHF

CVA Risk Factors: Negative Diabetes Hypertension Smoking Peripheral Vascular Disease CAD / Valvular Heart Disease

REVIEW OF SYSTEMS:		Pertinent Positives	Additional Pertinent History:
Constitutional	Neg	Fever Chills	PCP / Managing Physician(s):
Eyes	Neg	Photophobia Blurred Vision	Referred to ED / Clinic by: PCP / Telephone Referral / Other:
ENT	Neg	Sore Throat Ear Ache	Previous Visit for Same Complaint to ED / Clinic / PCP / In-Patient Within
Respiratory	Neg	Palpitations Chest Pain	72 Hours / Days Dx / Rx:
GI	Neg	SOB Cough	
GU	Neg	Vomiting Diarrhea	
MSkeletal	Neg	Dysuria Hematuria	
Skin	Neg	Arthralgia Myalgia	
Neuro	Neg	Rash Bruising	
Psych	Neg	Headache Weakness	
	Neg	Anxious Depressed	

All other systems reviewed and negative Yes No

Levels 2, 3, 1 System Level 4, 12 Systems Level 5, 10 Systems / Disclaimer

PAST MEDICAL HISTORY:		Previously Healthy	DNR / Comfort Care Only	PMH / FH / SH Levels 3, 10, 12 Level 4, 12 Level 5, PMH / FH / SH
Endocrine	DM I DM II Hypothyroid Hyperthyroid Dyslipidemia			Immunizations: Unknown Tetanus UTD Not UTD
CV	CAD / MI HTN CHF Afib DVT			* Pneumococcal * Influenza within 12 months
Respiratory	COPD Asthma Bronchitis Pneumonia PE			
GI / GU	PUD / GERD GI Bleed Urosepsis Diverticulitis Gall / Kidney Stones Chronic Kidney Dx			
Neuro / Psych	TIA / CVA Migraine Anxiety Depression Seizure Bipolar Disorder Schizophrenia PTSD			
Cancer	Lung Colon Breast Prostate			
Surgical Hx	None Cardiac Cath PTCA / Stent CABG Pacemaker Valve Replacement Aneurysm Repair Carotid Endarterectomy			

FAMILY HISTORY:	Negative
Heart / HTN	
Diabetes	
Other:	

SOCIAL HISTORY:	Negative
Smoking	ppd x yrs. * Patient Advised to Stop
Alcohol Counseling Time:	3+ min - 10 min / 10+ min.
Drug Use	
Occupation:	
Residence:	Alone With Family At Nursing Home

PHYSICAL EXAMINATION: EXAM LIMITED DUE TO: Dementia Altered Mental Status Extremis Other: _____

EXAM TIME: _____	Normal Findings: Well-Appearing No Pain Distress Well-Nourished PERL / EOMI Conjunctiva Clear Ears Normal Nose Normal Oropharynx Normal Supple Airway Patent CTA Breath Sounds Equal Respiration Nonlabored RRR Pulses Normal No Rub / Murmur Soft / Nontender No Masses Bowel Sounds Normal No Organomegaly Strength / ROM Intact No Edema No Calf Tenderness Warm & Dry Color Normal Sensory / Motor Intact Reflexes Intact CN Intact A & O x 3 Affect / Mood Appropriate	Abnormal Findings: Ill-Appearing: Mild / Mod / Severe Pain Distress: Mild / Mod / Severe Obese / Thin / Cachectic R Pupil _____ L Pupil _____ Conjunctiva Inflamed TMs Occluded Rhinorrhea / Epistaxis Erythema / Exudate / Dry Mucosa Nonsupple Airway Obstructed Crackles @ _____ Rhonchi @ _____ Wheezes @ _____ Retractions IRR (Tachycardia / Bradycardia) Abn. Pulses @ _____ Murmur Tender @ _____ Mass @ _____ Bowel Sounds Hypo / Hyper Hepatomegaly / Splenomegaly Limited @ _____ Edema @ _____ Calf Tenderness Pale / Diaphoretic Cyanosis @ _____ Focal Deficit @ _____ Abn. Reflex @ _____ CN _____ Palsy A/V P U Disoriented Anxious / Depressed	Complaint-Specific Findings JVD Carotid Bruit Rectal Heme pos / neg QC GCS _____ / 15 Nystagmus Gag Reflex pos / neg Meningeal Signs pos / neg Focal Weakness: None RUE LUE RLE LLE Facial Right / Left Focal Sensory Loss: None RUE LUE RLE LLE Facial Right / Left Gait: NL Ataxic Unsteady Unable Finger-to-Nose: NL Abnormal Right / Left Romberg pos / neg Babinski pos / neg Right / Left Heel-to-Toe: NL Abnormal Dix-Hallpike test pos / neg
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Neuro _____ Normal

Psychiatric _____ Normal

POOR QUALITY ORIGINAL

Cincinnati Stroke Scale

SPEECH: NL Slurred Dysarthric Aphasic

PRONATOR DRIFT: None / Present R / L

FACIAL SYMMETRY: Normal / Droop R / L

Level 1: 1 System Level 2: 2 Systems Level 3: 3 Systems Level 4: 4 Systems Level 5: 5 Systems Level 6: 6 Systems

DIFFERENTIAL DIAGNOSES / HQI / PQRI: Consideration of the following conditions may be warranted for the presenting problem; they are not final diagnoses.

Hypertension MI TIA Dysrhythmia Benign Paroxysmal Positional Vertigo Other: _____	Hyperventilation Hypovolemia / GI Bleed Labyrinthitis / Meniere's Medication Reaction	Metabolic Abnormal Seizure Vasovagal Reaction
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QUALITY INDICATORS:

For AMI: For Syncope:

- ▲ ASA Upon Arrival
- ▲ Thrombolytics w/in 30 Min
- ▲ PTCA w/in 90 Min
- ▲ LDL - c
- ▲ EKG Performed
- * Patient Advised to Stop Smoking

Alert / Code (circle): Trauma AMI Neuro

If Patient Pregnant, Indicate: Visit Related / Unrelated to Pregnancy

ED _____ **SES** _____

1 _____

2 _____

3 _____

Critical Care Provided: 30-74 min / 75-104 min / _____ min (Excludes time required for other billable procedures)

SIGNATURE: _____

I have reviewed available Ancillary / Nursing Staff documentation.

Disposition Time: _____

Disposition Date: _____

Teaching / patient and Resident's have docu _____

RE-EVALUATION: _____

Pain Scale (0-10)

Time: _____ Unchanged Improved Worse VSS

Time: _____ Unchanged Improved Worse VSS

PHYS. NOTIFICATION/CONSULTS: Chart Copy Available to Add'l Care Providers

Discussed _____ Patient with: _____

Name: _____ at _____ a.m. / p.m.

Name: _____ at _____ a.m. / p.m.

Admit/Transfer _____ Yes / No

Reviewed with: _____

Admit to: _____ Consult Follow-up: _____

DISPOSITION: RX: _____

Discharge: Home Work Nursing Home Deceased AMA

Admit: ED Obs InPt Unit: ICU OR Tele Floor Condition: Stable / Unstable

Patient Endorsed To/Discussed With: _____ @ _____ a.m. / p.m.

Patient Stabilized Within Hospital's Capabilities/Transferred to: _____

Transfer Form Completed _____

Disposition Rationale: _____

Discussed with: Patient Family Other: _____

After-Care Instructions Given to & Follow-Up Care Discussed w/Patient At Discharge

ORDER SHEET / NEURO / PSYCH COMPLAINT

Johnson City Medical Center

Emergency Department QualChart® Page 1 of 1

~ TIME ALL ORDERS ~

Obtain Medical Records: Old Chart Recent ED Chart Previous EKG Additional Records:

LABORATORY: Circle specific orders		By:	Time:	RADIOLOGY: Circle specific orders		By:	Time:
AMS Panel				CXR (2 view)	Portable CXR		
Adult Sepsis Panel				C-Spine	Port X-T C-Spine		
CBC	Manual Diff			3-View	5-View Flexion / Extension		
CMP	CMP			AAS	KUB		
UA	UA w/o Micro CC Cath			CT: Head / Facial Bones	Contrast: IV PO None		
UGG	HCG: Qual / Quant			CT: Chest	Contrast: IV PO None		
Drug Screen	Urine / Serum ETOH			CT: Abdomen / Pelvis	Contrast: IV PO None		
CPK	CKMB Troponin			Ultrasound of: ABD GB Pelvis			
D-Dimer	BNP Myoglobin			MRI: Brain	Contrast: IV PO None		
ESR	Uric Acid			Indication(s) for Xray / CT / US:			
PT / INR	PTT			Xray Interp: No Acute Changes Positive			
ASA	Acetaminophen			By: ED Physician Radiologist			
Digoxin				Pertinent Lab Values: WNL WNL Except:			
Dilantin	Depakote						
Tegretol	Phenytoin						
Cultures:	Urine Sputum Wound						
	Blood Blood x 2						
				POOR QUALITY ORIGINAL			
CARDIAC MONITOR / EKG INTERPRETATION: By: Time:				☐ EKG Rhythm Strip: Order and interpretation triggered by an event to help diagnose the presence or absence of an arrhythmia.			
Monitor: ☒ EKG				EKG Interpretation: <i>Bradycardia EKG</i>			
Rate: NL Brady Tachy				EKG Comparison: No Significant Change / Other:			
Rhythm: Sinus AFIB Junctional							
Ectopy: None PVCs PACs							
Axis: NL / Left / Right							
LBBB: New / Old /							
ST Segment: NL / Non-Specific							
TREATMENT ORDERS: By: Time: Time:				CLINICAL RESPONSE / RE-EVALUATION			
Repeat Vital Signs: All BP Pulse RR Temp O2 Sat				VSS except:			
Pulse O ₂ Q2 @ /min via NC / Mask / NRB				NL Hypoxic % on R/A or O ₂ @ /min			
Saline Lock IV: NS LR Bolus <i>1000</i> ml over <i>30</i> min/hr							
Maintenance IV: NS LR ml/hr							
Bedside Blood Sugar				Result: (60 - 100)			
D50 Amp IV D25 Amp IV				<i>Rocephin 2 g IV x 1</i>			
Narcan® mg IV				<i>Ac-Karyon 5cc</i>			
Activated Charcoal g PO NG OG (Peds 1-2 g/kg)				<i>Tylen 650 P.O.</i>			
Thiamine 100 mg IV IM							
Disposition Orders: Discharge Admit to InPt Status Observation Transfer							
Lumbar Puncture Time Out / Site Marked Per Facility Policy				Opening Pressure: mm/H ₂ O			
Time: a.m. / p.m. By: MD / DO				Closing Pressure: mm/H ₂ O			
Position: Sitting / Lateral Decubitus / Other:				Spinal Fluid Obtained / Unable to Obtain			
Anesthesia: Lidocaine / Other:				Fluid: Clear / Bloody / Cloudy ml			
Spinal Needle Used: g Attempts:				Results: WNL WNL Except:			
RE-EVALUATION: Unchanged Improved Worse				VSS except: Pain: (0-10)			
Time: a.m. / p.m.				Appearance: NAD /			
				Lungs: Clear /			
				Skin: Warm & Dry /			
				Neuro: A & O x 3 /			

SIGNATURE:

Time of Initial Orders:

Date: 6/17/12

Teach was pr

N / In

RN / Init

PA / NP / Resident

MD / DO

Revised and

ure(s).

(Initials)

This form is to assist the physician's documentation of clinical care and treatment.

It is not intended to supplant that judgement or create a standard of care.

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10/17/12 10:33 am



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HEALTH ALLIANCE**

MSHA Assessment Report

Pt Name: [REDACTED]
Pt ID: [REDACTED]
DOB: [REDACTED]
Adm DTime: 10/17/2012 01:34:00PM
Dsch DTime: [REDACTED]
Dx: MALAISE & FATIGUE NEC
Allergies: No Known Allergies, No Known Drug Allergies, No Known Food Allergies

MRN: [REDACTED]
Acct No: [REDACTED]
Age/Sex: 37Y/F
Atn Dr: [REDACTED]
Entity: JCMC

ED Triage

Assessment Sts Complete
Last Revised By [REDACTED] Collected DTime 10/17/2012 10:41

ED Triage

Triage Date/Time 2012-10-17 10:41:38
Accompanied by Self
Date of Injury 2012-10-17
Not suicidal or homicidal Yes
Name [REDACTED]
Patient's Pain Goal 0
Patient's Pain Goal 1 0
#BP#1 130/91
Respirations 18
Pulse Ox% 94
Temperature Site (ED) Temporal
Weight 111.13013 kg
Height 5/4 ft.in
Body Mass Index 42.05
Other Neurological Hx MR
Endocrine Hx Thyroidism, Unspecified
No Surgical History Yes
Advance Directive No
Triage Level 3 - Urgent
Weight in grams 111130.13

EDT Arrived Via Private Car
Primary Care Provider [REDACTED]
Triaged Chief Complaint weak and lethargic since
(ED) yesterday
Information From Family
Pain Intensity 0
Pain Scale Type Numeric
Pain Scale Type 1 (ED) Numeric
Pulse 133
On Room air Yes
Temperature (ED) 101.8
Universal Weight 245/0 lbs.oz
Weight Obtained By Stated
How Obtained Height Stated
Neurological Hx Seizures
Other Cardiac Hx Hyperlipidemia
No Behavioral Health Yes
History ED Triage
Date of LMP irregular periods
Patient Requested Adv Dir No
Information
Height in meters 1.63